MREL PRE-PROCEDURE SCREENING FORM

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Date_____/_____/_____

Name _____ Height_____ Weight_____
Last name First name M.I.

Birthdate_____

Address_____ City_____

State_____ Zip Code_____ Phone (H)(_____)_____ (W)(_____)_____

Physician's name & address_____

1. Have you ever had surgery or other invasive procedures? ❑ Yes ❑ No If yes, please list below.
   Type:_____ Date: _____/_____/_____
   Type:_____ Date: _____/_____/_____

2. Have you had any previous studies? ❑ Yes ❑ No If yes, please list below.

Area of Body	Date	Facility Name & Location
_____	_____/_____/_____	_____
_____	_____/_____/_____	_____

3. Have you ever worked as a machinist, metal worker, or in any profession or hobby grinding metal? ❑ Yes ❑ No
   had an injury to the eye involving a metallic object (e.g., metallic slivers, shavings, or foreign body)? ❑ Yes ❑ No

4. Are you pregnant, experiencing a late menstrual period, or having fertility treatments? ❑ Yes ❑ No

5. Are you currently taking or have recently taken any medication? ❑ Yes ❑ No Please list:_____

6. Do you have drug allergies or have you had an allergic reaction? ❑ Yes ❑ No Please list:_____

Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer for each of the following.

❑ Yes	❑ No	Cardiac pacemaker	❑ Yes	❑ No	Shrapnel, buckshot, or bullets
❑ Yes	❑ No	Implanted cardiac defibrillator	❑ Yes	❑ No	IUD or diaphragm
❑ Yes	❑ No	Aneurysm clip or brain clip	❑ Yes	❑ No	Pessary or bladder ring
❑ Yes	❑ No	Carotid artery vascular clamp	❑ Yes	❑ No	Tattooed eyeliner or eyebrows
❑ Yes	❑ No	Neurostimulator	❑ Yes	❑ No	Body piercing(s)
❑ Yes	❑ No	Insulin or infusion pump	❑ Yes	❑ No	Metal fragments (eye, head, ear, skin)
❑ Yes	❑ No	Implanted drug infusion device	❑ Yes	❑ No	Facelift or other cosmetic surgery on body
❑ Yes	❑ No	Spinal fusion stimulator	❑ Yes	❑ No	Internal pacing wires
❑ Yes	❑ No	Cochlear, otologic, or ear implant	❑ Yes	❑ No	Aortic clips
❑ Yes	❑ No	Ear tubes	❑ Yes	❑ No	Venous umbrella
❑ Yes	❑ No	Prosthesis (eye/orbital, penile, etc.)	❑ Yes	❑ No	Metal or wire mesh implants
❑ Yes	❑ No	Implant held in place by a magnet	❑ Yes	❑ No	Wire sutures or surgical staples
❑ Yes	❑ No	Heart valve prosthesis	❑ Yes	❑ No	Harrington rods (spine)
❑ Yes	❑ No	Artificial limb or joint	❑ Yes	❑ No	Metal rods in bones; joint replacements
❑ Yes	❑ No	Other implants in body or head	❑ Yes	❑ No	Bone/joint pin, screw, nail, wire, plate
❑ Yes	❑ No	Electrodes (on body, head or brain)	❑ Yes	❑ No	Wig, toupee, or hair implants
❑ Yes	❑ No	Intravascular stents, filters, or coils	❑ Yes	❑ No	Hearing aid ***(Remove before scan)***
❑ Yes	❑ No	Shunt (spinal or intraventricular)	❑ Yes	❑ No	Dentures ***(Remove before scan)***
❑ Yes	❑ No	Vascular access port or catheters	❑ Yes	❑ No	Asthma or breathing disorders
❑ Yes	❑ No	Swan-Ganz catheter	❑ Yes	❑ No	Seizures or motion disorders
❑ Yes	❑ No	Transdermal delivery system (Nitro.)	❑ Yes	❑ No	Claustrophobia

Please remove **all metallic objects** before MR examination including: keys, hair pins, barrettes, jewelry, watch, safety pins, paperclips, money clip, credit cards, coins, pens, belt, metal buttons, pocket knife, & clothing with metal in the material.

Earplugs are required during the MRI examination.

_____ _____/_____/_____
Signature of Person Completing Form Date

Form Completed by: ❑ Patient / Volunteer ❑ Relative:_____
❑ Physician:_____ ❑ Other:_____